In the Forefront

The Rural Health Program of Southern Monterey County

LEN HUGHES ANDRUS, M.D., *King City*

■ *The Rural Health Project of Southern Monterey County is attempting to demonstrate that a private group of physicians with the collaboration of the County Medical Society can responsibly and efficiently conduct a program of providing comprehensive medical care to indigent patients.*

Within the purposes of P.L. 89-749, the Rural Health Project is experimenting with a new way of organizing indigent health care and at the same time is providing the basis for comprehensive health planning at the local level.

THE OFFICE OF Economic Opportunity (OEO) is sponsoring 41 community and neighborhood health projects across the country (at a cost in 1967 of approximately fifty million dollars) which are aimed at providing medical care to poor people. The projects are situated in 32 different areas of 20 states. Four out of five projects are located in urban areas. Most are being conducted by community action agencies, poverty councils, health departments, hospital medical centers or medical schools. Three are connected with prepaid health plans (Kaiser in Portland, Oregon, Medical Foundation of Bellaire, Ohio, and Mound Bayou Community Hospital in Mississippi) and three are associated directly with medical societies (Fulton County Medical Society in conjunction with Emory University School of Medicine in Atlanta, the Provident [Negro] Medical Society in Brooklyn, New York, Lowndes, Alabama, and our own project in Southern Monterey County). Such projects are attempting to carry out one of the aims of comprehensive community health planning by demonstrating how Title XIX activities can be coordinated with existing health programs in our communities. Furthermore, data are being gathered which will aid in the planning of health services.

Public Law 89-749 stipulates that a majority of the members of state health planning councils shall be "representative of consumers." OEO grants also require that consumers participate in health planning. We accept this concept, but add three other essential ingredients to community planning: (1) The need for the private medical practitioner's voice in community health planning; (2) A leading role for the county medical society; and (3) The assurance that the evaluation of medical care is part of the planning.

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The author is Project Director for the Rural Health Project of Southern Monterey County, King City, California. The project is sponsored jointly by the Monterey County Medical Society and by the Southern Monterey County Medical Group. In addition to Dr. Andrus, other members are: Deane T. Brooke, M.D., Associate Project Director; Lee S. Roberts, Clinic Administrator; Edgar H. Colvin, Executive Secretary, Monterey County Medical Society; Jerome L. Schwartz, Dr. P. H., Medical Care Consultant, and Richard V. Bibbero, President Medical Management Control. This project is supported by Demonstration Grant No. CG9682 from the Community Action Program, Office of Economic Opportunity.

The Rural Health Project

The Rural Health Project of Southern Monterey County is unique because it combines all four of these elements: It represents the only community demonstration project sponsored by a medical society and conducted by a private medical group. We believe that the private sector of medicine should recognize the health needs of the community and take the initiative in meeting these needs. In those areas where it is impossible to meet the needs on the free enterprise or open market basis, then private medicine should seek assistance of the government and with governmental support and cooperation aggressively try to solve these health problems and maintain the reins of leadership.

The grantee for the Rural Health Project is the Monterey County Medical Society. The delegate agency is the Southern Monterey County Medical Group with offices in Greenfield and King City, California. The George L. Mee Memorial Hospital and the Pioneer Hacienda Nursing Home are collaborating agencies in the project. The application was supported by the county Community Action Program, the State and County Health Departments, the State Director of Anti-Poverty Planning, State Legislators and Federal Congressmen.

The program had its inception long before P.L. 89-749. In trying to meet the needs of the medical indigents of our area, the Southern Monterey County Medical Group had developed a plan for a pilot study to be underwritten by the Board of Supervisors of Monterey County. Our pilot study proposal was precluded when legislation at both the Federal (Title XVIII and Title XIX) and State (Casey Bill-AB 5) levels provided broadened programs to finance medical care for the needy. At this point we developed an application for a health demonstration grant funded by the Office of Economic Opportunity.

The Rural Health Project is designed to demonstrate the provision of comprehensive medical, surgical, hospital and other health services, through organized private group medical practice. The target population consists of about 800 poor families and an undetermined number of non-resident migrant farm workers. In the past these families have either lacked medical care completely or depended largely on the distant county hospital, 50 miles north of King City and 85 miles north of the southern boundaries of the county.

The project is identifying and serving all poor families in the area. "Health Aides" have been recruited from the eligible population itself and are being used to establish communication with the target population. They also serve as vital links between the needy and the service, the server and the served.

A research component is embodied in the project plan. Monies available from various sources to pay for care are identified and placed in a "pool." Funds committed for medical care from any source (such as Medicare, Medi-Cal and the Crippled Children program) will be paid back to the project in those cases where patients are eligible for them. All services and claims will be analyzed to provide valuable data for planning other health service for low income and indigent families.

Staffing and Training Phases

The use of public health and social welfare professionals in a private group and the feasibility of providing careers in the health field to members of indigent families are also being demonstrated.

Public health professionals added to the group's staff under the grant include a public health physician, a public health nurse and a health educator. Other professionals are two social workers and a community coordinator. The grant led to enlargement of our staff by adding several physicians, a registered nurse and an occupational therapist. A medical care specialist and statistician are providing technical assistance, particularly in the research and evaluative aspects of the project. Funds have also permitted us to expand our computer equipment and to lease three small buses. Recently we received approval to convert a motel near the office and hospital into an intermediate care facility. We are seeking a public health nurse and we hope in the future to broaden the program to include dental and mental health care.

An important aspect of the program is the training of persons from poor families—some with only grade school educations—for careers in the health field. In rural areas in particular, there are shortages of skilled health aides. When our project staff is at full complement, we will be training 35 aides in 14 different phases of our program. The wide scope of the training program is revealed from the various kinds of aides to be employed: physical therapy trainee, occupational therapy trainee, x-ray trainee, laboratory trainee, IBM trainee, medical secretary trainee, medical clerk trainee, social

work aide, home health and language aide and transportation aide. Twenty aides will be trained in the fields just mentioned, and the other 15 will be trained in three subprofessional nursing positions—clinic nursing aide, hospital nursing aide and nursing home aide. This experience in training persons from the indigent population has been one of the most exciting and rewarding functions of our project.

Home Health Care Agency

We have the necessary components of a licensed Home Health Care Agency, a physician, medical director, public health nurse, social worker, public health nurse and social worker, and the additional personnel of a physical therapist and an occupational therapist. We are already using the Home Health Care Agency personnel extensively and not only hope to demonstrate its value in service to patients but also that it can be a self sustaining if not a profitable function of a private medical group.

Problems and Accomplishments

The project has been in operation for only four months. It is noteworthy that the government has granted us complete autonomy to administer the project as we see fit. Although we have accomplished a great deal in this short period, we have had some difficult problems. The major problems have been shortage of physicians, lack of sufficient space, difficult policy determinations, coordination of the project with the clinic, hospital, nursing home, motel and consultants, the establishment of a five night per week evening clinic to 10:00 p.m., resistance among our personnel, the training of a large number of aides, broken patient appointments, and education of the target population to proper utilization of medical facilities.

The government may have been reluctant at first to permit a private group of physicians to establish and operate a community program for indigents. Most other grantees are non-profit groups or governmental agencies. We have surprised many interested people with our speed in beginning to provide patient care. Our project began on 11 June and we began seeing patients 18 July. Only eight of the 41 community health projects, including our program, have begun serving patients.

We had distinct advantages, in that we were an ongoing medical group with facilities, equipment, a skilled staff and accounting-computer capability. Of course, the increased load of patients and the need to recruit additional staff has presented us the problems and forced us initially to limit the number of new patients. But we have been able to carry out some of the immediate steps of the project faster than community or government-sponsored grantees. We have also pre-tested and developed a social history form to provide data relating to demographic, social and health characteristics of our project patients. Another form which we have put into operation — The Patient Care Contact form—provides data relating to each patient contact with the project, including the reason for the visit, the medical diagnosis and the disposition of the case. We made some changes in our IBM system and will be able to analyze all medical, paramedical and hospital services provided to project patients in terms of the patient's social characteristics, medical diagnoses and costs.

We have established a mechanism whereby the Monterey County Medical Society, through a medical review team, is examining our records and claims. We are also performing an internal medical audit and a medical care specialist is reviewing our overall program.